Before the
Federal Communications Commission
Washington, D.C. 20554

In the Matter of	)	
	)	
Promoting Telehealth for Low-Income Consumers	)	WC Docket. No. 18-213
	)	
	)	

COMMENTS OF MEDICAL HOME NETWORK IN RESPONSE TO THE NOTICE OF INQUIRY

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I. INTRODUCTION

The Commission's proposal to allocate resources to advance broadband-enabled telehealth services is timely and important. We firmly believe, based on firsthand experience, that the proposed Connected Care Pilot Program (the Program) can improve health outcomes and reduce the overall cost of care among low-income Americans. At Medical Home Network, we use innovative telehealth technologies to enhance patient care, and have demonstrated that they increase efficiency and yield measurable improvements in health outcomes. We appreciate this opportunity to draw upon that experience to address many of the issues facing the Commission as the scope and objectives of the Program are established. In our comments, we share insights gained from implementing the eConsult system, which continues to improve specialty care access, reduce fragmentation and cost, and enhance quality of care in the Cook County Health and Hospitals System and the Los Angeles County Department of Health Services system, among others.

II. COMMENTS

A. Program Goals

> **1. Types of Projects.** *Should we give priority to certain projects over others, and if so, on what basis?...Additionally, should the pilot program focus on particular health conditions, areas of medicine, or health crises? We seek comment on these and any other issues commenters believe are relevant in determining how to most effectively allocate the pilot program's resources.*

It is commonly understood in health care that increased access to specialty care leads to improved health outcomes, as patients are treated by specialists with the knowledge and expertise to best diagnose and treat conditions before they worsen. Yet the authors of a 2018 study from *The American Journal of Managed Care* observed that "Few efforts have been directed at improving the interface between primary care providers (PCPs) and specialists in the outpatient setting, …[which] is notable given the significant clinical importance and financial impact of the PCP–specialist relationship."[1]

Difficulties obtaining access to specialty care in the Medicaid and uninsured populations are well documented, and include:

- Challenges faced by patients in adhering to treatment plans because of non-medical challenges (for example, transportation availability) that result in missed specialist appointments;[2]
- Administrative burdens associated with scheduling;
- Long wait times for specialty appointments.[3]

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[1] Anderson, Villagra, Coman, Zlateva, Hutchinson, Villagra, & Olayiwola, *A Cost-Effectiveness Analysis of Cardiology eConsults for Medicaid Patients*, American Journal of Managed Care (Jan. 2018) at https://www.ajmc.com/journals/issue/2018/2018-vol24-n1/a-costeffectiveness-analysis-of-cardiology-econsults-for-medicaid-patients.

[2] *See, e.g.,* Felland, Lechner & Sommers, *Improving Access to Specialty Care for Medicaid Patients: Policy Issues and Options,* The Commonwealth Fund (June 2013) at 7.

[3] MHNU Corporation, *Leveraging Technology to Reduce Barriers to Specialty Care* (March 2016) at 1 (see Exhibit A hereto).

A program that permits patients to be treated by a specialist in a timely and efficient manner bolsters patient engagement, thus improving attendance at future appointments and adherence to treatment plans. Indeed, we have seen this result firsthand with the success of the eConsult system, which provides primary care physicians (PCPs) and care teams a secure, web-based platform to communicate quickly and effectively with specialists. Through eConsult, PCPs submit an electronic consult to a specialist to ask questions relevant to patient care, procure recommendations for treatment or testing, and establish the appropriateness of a referral.

The case for the importance of faster access to specialists is best illustrated in the following anecdote from a physician with Esperanza Health Center (a Chicago federally qualified health center), who used eConsult to confer with a specialist at the Cook County Health and Hospitals System (CCHHS):

> "An Esperanza provider sent an eConsult with a photograph for a patient with a concerning skin lesion [to a CCHHS dermatologist]. Prior to eConsult, it would have taken the patient 3-6 months to be seen [by a dermatologist] at CCHHS. Upon seeing the concerning photograph, the dermatologist scheduled the patient to be seen within one week. The dermatologist's biopsy showed skin cancer, which was fortunately caught before it became metastatic and the patient was treated appropriately. In this dramatic case, the innovative eConsult system literally saved the patient's life."

In light of eConsult's initial success, we believe the Commission should focus at least one pilot on a large urban population, where there is a greater concentration of patients, and within that population, priority should be given to conditions with an increased likelihood of avoidable, debilitating and expensive consequences. For example, early intervention for diabetic retinopathy (ophthalmology) or potentially malignant skin lesions (dermatology) will deliver actionable insights regarding efficacy of each program. Telehealth, specifically eConsult, works very well with these particular specialties because the specialist is able to see an image in order to provide a recommendation. Similarly, medication management questions for psychiatrists benefit from telehealth services as the PCP is often not in a position to treat the patient's mental health needs during a physical exam. Even specialties that typically have high face-to-face closures, such as urology and gastroenterology, work well with a model like eConsult because the specialist can triage the case using the program, recommend treatment beforehand, and support a more valuable in-person visit in the future.

Moreover, once connected care programs become more broadly available, reaching rural communities will be more effective if the Commission has a recipe for success upon which it can rely. In fact, in rural areas where specialists are not available to review eConsults, the eConsult system can support a centralized specialty network that coordinates with PCPs. To that end, supporting an eConsult pilot which addresses the common barrier of difficult access to specialist care for PCPs and care teams trying to deliver high-quality, coordinated care for patients, particularly in hard-to-reach urban populations, will help ensure that the roll-out of other programs is based on sound evidence of systems that work.

> **2. Measuring Patient Health Outcomes and Behavior.** *Since the fundamental goal of the pilot program is to improve health outcomes among low-income Americans through the use of expanded access to telehealth services, we seek to measure the effectiveness of the pilot program in promoting better health among*

qualifying patients. We seek comment on which metrics should be used to measure improvements in the health of qualifying patients.

The following metrics of success for the eConsult platform could also be utilized to indicate health care improvements for qualifying patients participating in the Program:

- Faster access to specialists (as measured by time between the eConsult submission and specialist's response time. For eConsults that result in face-to-face closure, date of the eConsult closure by the specialist and the date of the first appointment with the specialist)
- Improved patient satisfaction (as measured by a survey of patients who have participated in the Program)
- Improved quality of care (as measured by treatment outcomes, reduced hospital stays, etc.)
- Increase in the efficient use of specialists' time (as measured by fewer no-show appointments and fewer unnecessary referrals)

Initial studies have demonstrated that by using a peer-to-peer approach that allows physicians to communicate at their convenience, most eConsult cases are resolved without the need for face-to-face visits and specialists can focus on complex patient cases.

For instance, CCHHS, which began using eConsult as a pilot project in 2015 and entered into a contract with 200,000 eligible patients in 2016, boasts an 89% show rate for scheduled specialty appointments.[4] Los Angeles County Department of Health Services system (LACDHS), with 900,000 eligible patients, has experienced a 60% reduction in average wait time for a specialty appointment since implementing eConsult in 2012.[5] In both locations, there is on average a 50% reduction in face-to-face appointments required with specialists.[6] While the eConsult program was introduced as an experiment, it has been so successful that doctors are using it on a daily basis at both CCHHS and LACDHS; in fact, within LACDHS alone, nearly 4,500 providers from over 400 clinics used the system in 2017.[7] A 2017 study of the LACDHS eConsult System in the journal *Health Affairs* found that the median time to a specialist appointment decreased significantly while the volume of visits remained stable, and concluded that "eConsult systems are a promising and sustainable intervention that could improve access to specialist care for underserved patients."[8]

In view of these promising early results, eConsult and other similar programs could greatly benefit from additional resources and funding to better track, evaluate and improve upon their existing systems.

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[4] MHNU Corporation, *What is eConsult?* (2016) at 1 (see Exhibit B hereto).

[5] *Id.*

[6] *Id.*

[7] Gorman, Anna, *Los Angeles County Scores an E-Success in Managing Specialist Care*, Kaiser Health News (Mar. 8, 2017) at https://khn.org/news/los-angeles-county-scores-an-e-success-in-managing-specialist-care/ (Kaiser Health News is a nonprofit news service covering health care policy and politics and is not affiliated with Kaiser Permanente).

[8] Barnett, Yee, Mehrotra & Giboney, *Los Angeles Safety-Net Program eConsult System Was Rapidly Adopted and Decreased Wait Times to See Specialists*, Health Affairs, Vol. 36, Iss. 3 (Mar. 2017) https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.1283.

> **3. Reducing Rising Healthcare Costs.** *We seek comment on using the pilot program to help reduce the rising health care costs faced by consumers and health care facilities. How can the pilot program improve health care affordability for low-income Americans and counteract the burdens of increasing out-of-pocket expenses, including transportation costs for rural and remote patients? How can the pilot program reduce health care expenditures for participating health care providers and their qualifying patients? Can support for telehealth services for low-income patients create savings for Medicaid, and in turn, lessen burdens for taxpayers? To the extent that remote patient monitoring and connected care technologies more generally continue to reduce the overall costs of healthcare in the country, what steps can be taken to incentivize payors in the healthcare system to more fully support the long-term deployment and use of these technologies?*

We believe that by increasing communication between the PCP and specialist, expediting wait times for patient appointments, and reducing unnecessary referrals and emergency room visits, programs like eConsult help reduce healthcare costs. However, as mentioned above, we have not had the resources to conduct a specific evaluation on the effects of PCP access to a secure eConsult platform on total healthcare expenditures. We strongly encourage the Commission to consider eConsult for the Program so that we may obtain concrete baseline data of the cost savings that can be achieved with this system.

> **4. Measuring Health Care Savings.** *We seek comment on measuring the savings to patients, providers, and the health care system as a result of the pilot program. In a 2012 report on the Rural Health Care Pilot Program, the Wireline Competition Bureau summarized the cost savings that participating health care providers reported as a result of the pilot program funding. For example, the Palmetto State Providers Network in South Carolina reported savings of $18 million in Medicaid costs over 18 months as a result of its tele-psychiatry program, which used a network built with up to $8.3 million in funding from the Rural Health Care Pilot Program. We believe that a similar evaluation of the impact of the Connected Care Pilot Program on health care costs would be useful to measuring its success. We seek comment on this view and on specific metrics that could be used to assess the cost savings resulting from the pilot program. For example, should we collect data on participating health care providers' savings from fewer and/or shorter hospitals stays, reductions in emergency hospital transports, or reductions in costs associated with traveling to patients? Additionally, should we measure health care-related savings for participating low-income patients as a result of the pilot projects, and if so, how? For example, should we collect data on participating patients cost savings from decreases in patient costs for hospitalizations or hospital transports, or savings in time and expenses associated with patient travel to doctors' offices?*

The study from *The American Journal of Managed Care* reported that "Outpatient specialty visits represent a disproportionate source of year-over-year increases in healthcare expenditures, with research suggesting that a typical PCP interacts with more than 200 specialists in a year."[9]

[9] Anderson, et al (citing Starfield, Chang, Lemke & Weiner, *Ambulatory specialist use by nonhospitalized patients in*

This initial study evaluated the cost savings to payers of eConsults for Medicaid-insured cardiology patients compared with traditional face-to-face specialist consultations in a statewide federally qualified health center. The study's authors assessed the total cost of care and cost across seven categories: inpatient, outpatient, emergency department, pharmacy, labs, cardiac procedures, and "all other."[10]

The short-term results were significant: six months after the initial cardiology consult, patients whose PCPs had used eConsult to communicate with cardiologists had on average $655 in total cost savings per patient, and specifically $81 per patient in the outpatient cardiac procedures category.[11] The study's authors concluded that because eConsult "improves access, timeliness, and coordination of care compared with traditional face-to-face consultations," that the use of eConsult "could result in significant savings to the Medicaid program in a relatively short time frame."[12] In other words, this preliminary study demonstrates that eConsult permits health systems to simultaneously improve quality of care while also reducing costs.

Should eConsult be selected to participate in the Program, it would be valuable to obtain longer-term results that measure savings in time and expenses associated with patient travel to appointments. Obtaining data on cost savings from fewer unnecessary specialist appointments, including reductions in work days missed attending unnecessary specialist appointments, would also be helpful. And, on a long-term basis, measuring improved health outcomes as a result of decreased time spent waiting to see a specialist and increased patient engagement would be particularly beneficial.

B. Structure of the Program

1. Eligible Low-income Subscribers. *We seek comment on requiring participating health care providers to use the pilot program benefits exclusively for low-income patients. Specifically, we seek comment on limiting the participating health care providers' use of the pilot program funding to Medicaid-eligible patients, as well as veterans who qualify based on income for cost-free health care benefits through the Department of Veterans Affairs (VA). We believe that focusing on Medicaid patients and veterans who qualify for cost-free health care through the VA based on income would ensure that pilot program funds are appropriately targeted to low-income individuals, while also relieving participating hospitals and clinics of the burdens that would otherwise be associated with determining whether individual patients receiving broadband services funded by the pilot program qualify as low-income. We seek comment on this view and on any alternative requirements.*

We fully support the Commission's contemplated limitation on the use of pilot program funding for (a) Medicaid-eligible patients, and (b) veterans who qualify based on income for cost-free health care benefits through the Department of Veterans Affairs, for the reasons set forth by the Commission.

US health plans: correlates and consequences, J Ambul Care Manage (2009); Barnett, Song & Landon, *Trends in physician referrals in the United States, 1999-2009*, Arch Intern Med (2012); Pham, O'Malley, Bach, Saiontz-Martinez & Schrag, *Primary care physicians' links to other physicians through Medicare patients: the scope of care coordination*, Ann Intern Med (2009)).

[10] Anderson, et al.

[11] *Id.*

[12] *Id.*

2. Location. *Should we consider location as a factor in selecting participating clinics and hospitals? If so, should the pilot program prioritize participating clinics and hospitals in rural areas? Should the pilot program prioritize communities that have lost clinics, local hospitals, or specific services for patients such as obstetric and gynecological physicians or maternity wards? Or should it seek geographic diversity by including clinics in both urban and rural locations?*

We believe the Program can make a bigger impact if urban populations are included. Additionally, a higher volume of patients will allow for a larger statistical sample and more accurate and meaningful results.

3. Duration. *We seek comment on the duration of the pilot program and whether we should adopt a two- or three-year funding period. Would such a timeframe be sufficient to obtain meaningful data and promote long term adoption of broadband-enabled telehealth services? Is two or three years of funding long enough to observe metrics to evaluate the pilot program's performance? Should we consider a longer funding period, particularly given our objective to encourage network deployment and the amount of time such deployment can take? We expect to include a time period before the pilot program commences to allow for the formation and organization of partnerships and a period for enrollment. Similarly, we expect the program to be followed by an evaluation period. We seek comment on this approach. Would providing a six-month ramp-up period and a six-month wind-down period be sufficient?*

Depending on the scale of the project, the six-month ramp up and six-month wind down period should be sufficient. A five-year program would provide a better opportunity to observe and measure patient health outcomes (e.g., reductions in emergency room visits, lower Hgb a1c levels, blood pressure management, etc.). However, in two to three years, qualitative data could be collected from patients and providers, and short-term health outcomes could be assessed near the conclusion of the program.

4. Support for End-User Devices. *We also seek comment on providing pilot program support for end-user devices. Should the pilot program fund equipment used to provide connected care services, such as remote patient monitoring equipment? What about tablets or smartphones that could be used for the telehealth applications but would also enable access to many other non-telehealth applications? Should the pilot program fund mobile health applications selected by the participating health care providers for use by their participating patients?*

We agree that the Program should fund equipment used to provide connected care services, such as remote patient monitoring equipment. We further agree that the tablets and smartphones used for telehealth applications would also enable access to other non-telehealth applications. Finally, we agree that the Program should fund mobile health applications selected by participating providers for use by their participating patients.

IV. CONCLUSION

The Commission's proposed Program to help advance broadband-enabled telehealth services could benefit greatly from the inclusion of an established, innovative service like eConsult. Studies prove that eConsult achieves one of the Commission's primary objectives for the Program: permitting health systems to simultaneously improve quality of care while also reducing costs. With additional resources and funding through the Program, eConsult could

reach an even larger population of low-income patients, enable the collection and evaluation of additional data, and greatly improve health outcomes.

Exhibit A

Leveraging Technology to Reduce Barriers to Specialty Care*

Medical Home Network and Cook County Health and Hospitals System (CCHHS) are using innovative technologies to improve specialty care access, reduce fragmentation and cost, and enhance quality of care.

Difficulties getting access to specialty care in the Medicaid and uninsured populations are well documented, and include:

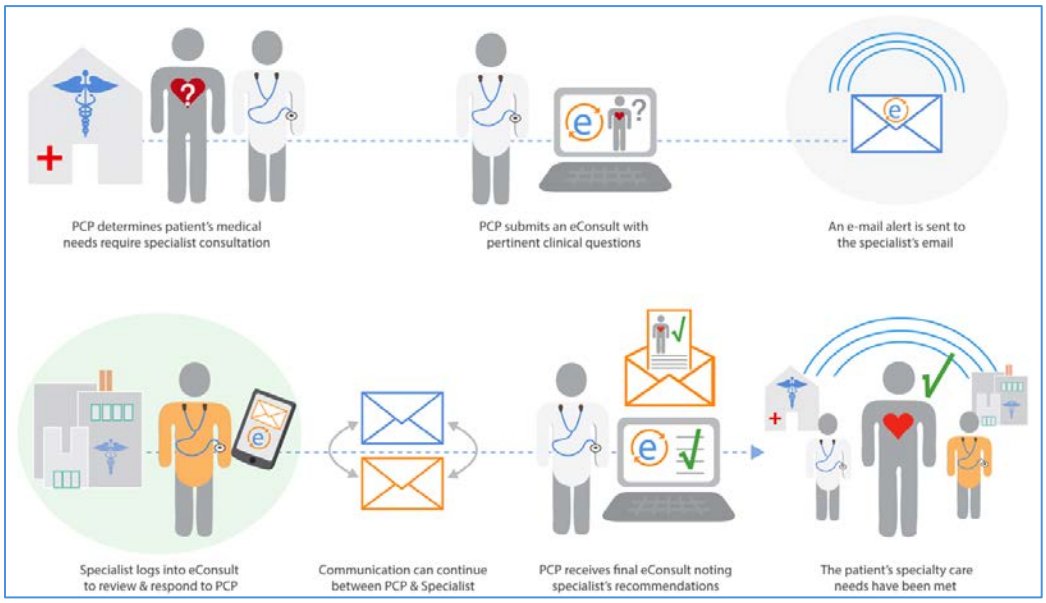
- Low payment rates;
- Administrative burdens associated with scheduling;
- Difficulties patients have adhering to treatment plans because of non-medical challenges (for example, transportation availability) that result in missed specialist appointments;[1] and
- Long wait times for specialty appointments.

Models showing early success addressing these obstacles take three primary approaches:

- Increasing the availability of specialists in part by addressing payment issues;
- Expanding the ability of primary care providers to address specialty care needs, reducing the need for face-to-face specialist visits; and
- Enhancing communication and coordination.[2]

How Does eConsult Work?

The eConsult program connects safety net primary care providers (PCPs) with specialists who have agreed to serve patients either through the eConsult system or, if indicated, an in-person visit.



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* **Disclaimer - No Legal Advice**: Information in this summary and your receipt or use of it (1) is not provided in the course of and does not create or constitute an attorney-client relationship, (2) is not intended as a solicitation, (3) is not intended to convey or constitute legal advice, and (4) is not a substitute for obtaining legal advice from a qualified attorney. You should not act upon any such information without first seeking qualified professional counsel on your specific matter. The information in this summary was last updated in March 2016.

[1] *See, e.g.,* Felland, Lechner & Sommers, *Improving Access to Specialty Care for Medicaid Patients: Policy Issues and Options,* The Commonwealth Fund (June 2013) at 7.

[2] *Id*. at 10.

The technical infrastructure for eConsult is simple; no significant investment in training or hardware is required. However, before trying eConsult, some organizations and providers have had questions regarding the logistics and potential risks of using electronic consult services. The brief summary that follows addresses frequently asked questions.

Professional Liability Risks

FAQ #1. How Do eConsults Differ from "Curbside Consults"?

Curbside consults are an informal process used by providers to obtain advice from another provider to assist in the management of a particular patient. The consulted physician usually is not familiar with the patient, and has neither examined the patient nor reviewed the patient's chart.[3] The consulted physician typically is not compensated for their time and expertise in a curbside consult.[4]

Most primary care physicians and subspecialists participate in *at least* one informal consultation per week.[5] In the Medicaid and uninsured populations, these figures may well be higher because fewer specialists are willing to accept these patients or the higher risk of patient no-shows.

The primary risk inherent with curbside consultations is that the lack of necessary patient information may lead to improper clinical advice from the specialist that is then relied upon by the PCP.[6] eConsult provides structure, information and documentation to mitigate that risk. This side-by-side comparison highlights some advantages of eConsults:

Curbside Consult[7]	**eConsult**
Informal	Formal
Entire interaction is verbal or documented solely in the requesting physician's record	Written query from PCP and response from specialist are part of patient eConsult record
Specialist is unfamiliar with the patient, has not reviewed the patient's chart, has not examined the patient and must rely on oral report from consulting physician's memory or understanding of the patient's records	Specialist receives written summary from consulting physician, and PCP may also attach relevant materials from the patient's medical record
May involve insufficient or inaccurate clinical information	Specialist has opportunity to request additional information and tests, and to review primary source materials (e.g., actual lab results, rather than consulting physicians reported memory of lab results)

[3] Susan Shepard & Carol Murray, *Curbside Consultations*, at http://www.thedoctors.com/KnowledgeCenter/PatientSafety/articles/Curbside-Consultations (Dec. 2014) (The Doctors Company is the nation's largest physician-owned medical malpractice insurer.)

[4] Cliff Rapp, *Liability Perspective: Curbside Consults,* http://scmsociety.typepad.com/members_center/files/curbside_consults_91206.pdf (Sept. 12, 2006) (Mr. Rapp is Vice President of Risk Management at First Professionals Insurance Company, Inc.).

[5] *Id.* (reporting that 70% of PCPs and 68% of specialists participated in at least one curbside consult per week).

[6] *See* Shepard & Murray on the drawbacks of curbside consultations.

[7] *Id.*

Specialists' recommendations are filtered by receiving physician and if recorded at all, are recorded by the consulting physician	Specialist recommendations are documented
If specialist requests an opportunity to examine the patient, this request may not be recorded in the record	Specialist request to examine patient becomes part of the eConsult record and is immediately sent to a Scheduler's worklist for appointment scheduling

FAQ #2. Do eConsults Increase Liability Risks?

Providers often ask[8] whether conducting eConsults exposes them to heightened tort or personal injury risk. It has been consistently reported by risk managers, attorneys representing professional liability insurers, and specialists that liability risks associated with telemedicine are low.[9] In fact, "[t]he current consensus across an array of leading Medical Professional Liability insurers is that they are . . . not overly concerned regarding telemedicine as an area of risk, recognizing it as . . . a means of delivering professional services with which the insurers overall are generally comfortable and already insuring."[10]

Relatively few published decisions address liability arising from services like eConsult or real-time, live services that fall within the legal definition of telehealth. Those that do confirm two basic principles:

1. The same general licensing, privacy, ethics, documentation, records preservation, and care standards apply to electronic consults and consults that occur in traditional settings.[11]

2. Many jurisdictions require providers to be appropriately licensed and credentialed to provide services where their patients and practice are located. This may require a legal review of medical staff bylaws, rules, and accreditation standards to determine whether the physician at the "distant" site must satisfy the originating site's credentialing requirements.[12]

Finally, risk managers recommend that providers confirm that their malpractice insurance covers the type of encounters occurring under the eConsult system, and ensure that they are adhering to all state regulations about the recording and storage of information obtained through telemedicine.[13] Additionally, risk managers recommend that providers have robust cyber liability coverage in place to protect against network security and patient privacy exposure associated with conducting telemedicine.[14]

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[8] As noted in the disclaimer above, information in this summary and your receipt or use of it is not intended to convey or constitute legal advice; however, many governmental employees are entitled to immunity from tort liability or indemnification for activities performed in the scope of their official duties. See, for example, Cook County Code of Ordinances § 38-89. Seek legal advice from a qualified attorney regarding the applicability of any such immunities to your circumstances.

[9] *See* Felland, Lechner & Sommers at 13 ("Cardiologists in the [Community Health Centers, Inc.] eConsults pilot feared PCPs would submit patients with overly urgent and complex conditions, resulting in delayed, substandard care, and potential exposure to malpractice liability. However, these problems did not materialize . . . ."). *See also* Hilary Daniel & Lois Snyder Sulmasy, *Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings: An American College of Physicians Position Paper* 163 ANN. INTERN MED. 10, 787-789 (Nov. 17, 2015) ("The examples of legal challenges [regarding telemedicine] are primarily alleged illegalities in prescribing drugs over the Internet and not a result of physicians providing negligent care through telemedicine.")

[10] Jacqueline Bezaire & Robert L. Snyder, *Telemedicine: Understanding the Risks*, Willis Health Care Practice HealthTrek (June 2015) at 5 (14329_PUBLICATION_Health_Trek_Telemedical_Liab.pdf) (Willis is an international risk management and insurance brokerage firm).

[11] *See, e.g., United States v. Rodriguez*, 532 F.Supp.2d 316, 327 n.6 (D.P.R. 2007) ("The best philosophy and approach to telemedicine is that the same standards of care and protocols applicable to more traditional forms of medicine exist with telemedicine.") Medical professional liability insurers take the same approach: *See* Bezaire & Snyder at 5 ("Essentially the same criteria are used [by Medical Professional Liability insurers] to underwrite the 'professional' risk associated with services provided from a 'distant site' as are used for services being provided at an established medical site.").

[12] *See* Bezaire & Snyder at 5. *See also* AHLA Health Law Glossary, "Telemedicine: Liability" at https://www.healthlawyers.org/hlresources/glossary/healthlaw/Telemedicine.aspx (citing the Federation of State Medical Boards of the United States' 2001 "Model Guidelines for the Appropriate Use of the Internet in Medical Practice").

[13] *See* Daniel & Sulmasy at Position Paragraph 8.

[14] Bezaire & Snyder at 5.

Coverage and Reimbursement for Telehealth Services in Illinois*

Payment and coverage for telehealth services vary greatly across the country. The following section is intended to help providers who use the eConsult system understand: (1) how various state authorities address telehealth coverage; (2) whether eConsults may be reimbursed by third party payors including Medicare and Medicaid; and (3) how other states are addressing telehealth coverage and reimbursement.

FAQ #3. How Does the Illinois Insurance Code Address Telehealth Coverage?

In the Illinois Insurance Code, the State takes an "if, then" approach to telehealth insurance coverage: if a health plan regulated by the Code chooses to cover telehealth services, then the plan is prohibited from:

- requiring in-person contact between a provider and a patient;
- requiring the provider to document any barriers to an in-person consultation;
- requiring the use of telehealth when it is deemed by the provider to not be appropriate or when the patient chooses an in-person consultation; or
- charging more for deductibles, copayments, or coinsurance for telehealth services than for the same services provided through an in-person consultation.[15]

However, the Illinois Insurance Code narrowly defines "telehealth services" to mean "the delivery of covered health care services by way of an interactive [live] telecommunications system."[16]

FAQ #4. Will eConsults be Reimbursed by Illinois Medicaid?

Individual coverage determinations regarding are very fact-specific, and billing decisions must be made by providers in consultation with their own reimbursement experts and legal advisors. As a general matter, however, to qualify for reimbursement as telehealth services under Illinois Medicaid, services provided via eConsult must fall within the Illinois Department of Healthcare and Family Service's ("HFS") definitions of "telemedicine" or "telepsychiatry" and satisfy other regulatory requirements for reimbursement.[17] In January 2010, Illinois submitted a proposal for a CMS § 1115 waiver that included the development of a statewide specialty telemedicine network, but approval of this waiver is still pending.[18]

The Illinois Administrative Code definition of "telemedicine" allows email as a form of telecommunication if the email from the provider at the site where the patient is located (the "Originating Site") includes visualization of the patient that is "specific to the patient's medical condition and adequate for furnishing or confirming a diagnosis and/or treatment plan."[19] The regulations draw a distinction between emails with such

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[15] *Id.*

[16] "'Interactive telecommunications system' means an audio and video system permitting 2-way, live interactive communication between the patient and the distant site health care provider." 215 ILCS 5/356z.22(a).

[17] "Telehealth" means services provided via a telecommunication system. "Telemedicine" means the use of a telecommunication system to provide medical services for the purpose of evaluation and treatment when the patient is at one medical provider location and the rendering provider is at another location. "Telepsychiatry" means the use of a telecommunication system to provide psychiatric services for the purpose of evaluation and treatment when the patient is at one medical provider location and the rendering provider is at another location. 89 Ill. Admin. Code 140.403(a) (Jan. 29, 2010).

[18] Melesa A. Freerks, Nathaniel M. Lacktman & Taylor E. Whitten, Illinois Telemedicine Rules: Licensing, Practice, Payment, (Feb. 25, 2016) https://www.healthcarelawtoday.com/2016/02/25/illinois-telemedicine-rules-licensing-practice-payment/ (accessed March 22, 2016).

[19] 89 Ill. Admin. Code § 140.403(a) (Jan. 29, 2010).

visualizations and text-only e-mails, phone calls, or fax images from an Originating Site provider. The latter category of communications (text only e-mails, phone calls and fax images) do not qualify for reimbursement under the current Administrative Code provisions.[20]

In January 2010, Illinois submitted a proposal for a CMS § 1115 waiver that included the development of a statewide specialty telemedicine network, but approval of this waiver is still pending. The HFS *Handbook for Practitioners Rendering Medical Services* (the "HFS Handbook") states that:

> Medical data exchanged can take the form of multiple formats: text, graphics, still images, audio and video. The information or data exchanged can occur in real time (synchronous) or in *near real time (asynchronous) through "store and forward" applications*. The telecommunication system must, at a minimum, have the capability of allowing the consulting practitioner to examine the patient sufficiently to allow proper diagnosis of the involved body system. The system must also be capable of transmitting clearly audible heart tones and lung sounds, as well as clear video images of the patient and any diagnostic tools, such as radiographs.[21]

Bottom Line: eConsult is a telecommunications system that delivers asynchronous store and forward applications. *If used in accordance with other billing requirements*, eConsult enables the performance of telehealth services that qualify for Medicaid reimbursement in Illinois.

However, to complicate matters further, where an encounter clinic (which includes clinics operated by an Illinois county with a population over three million) is either the Originating Site or the location of the rendering provider (the "Distant Site"), HFS currently appears to limit reimbursement to those communications made with real-time telecommunication systems:

> The encounter clinic must bill procedure code T1015 with the appropriate Current Procedural Terminology (CPT) code *and modifier GT (via interactive audio/video telecommunication systems)* for the service rendered by the Distant Site.[22]

By comparison, the question of reimbursement for telepsychiatry eConsults is more easily answered: reimbursement under the current Illinois Medicaid regulations is not permitted because the current guidelines expressly require the use of interactive real-time telecommunication systems to administer telepsychiatry services.[23]

a. Location and Provider Requirements

Illinois Medicaid regulations regarding reimbursement for telehealth services place restrictions on reimbursement eligibility based on (i) the location where services are being delivered, and (ii) the type of providers delivering the services. A patient must be at one medical provider location (the Originating Site) and the rendering telehealth provider must be at another site altogether (the Distant Site).[24]

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[20] *Id*.

[21] Illinois Department of Healthcare and Family Services, *Handbook for Practitioners Rendering Medical Services: Chapter A-200 Policy and Procedures for Medical Services*, Issued August 2010 at HFS A-220(6) (http://www.hfs.illinois.gov/assets/a200.pdf) (emphasis added). Real time exchanges may occur through interactive video or multimedia collaborative environments. HFS Informational Notice, *Re: Expansion of Telehealth Services*, Jan. 12, 2010 (http://www.hfs.illinois.gov/html/011210n2.html) (accessed Mar. 22, 2016).

[22] HFS Informational Notice, *Re: Expansion of Telehealth Services*, Jan. 12, 2010 (http://www.hfs.illinois.gov/html/011210n2.html) (accessed Mar. 22, 2016) (emphasis added).

[23] 89 Ill. Admin. Code § 140.403(b)(2)(e) (Jan. 29, 2010).

[24] 89 Ill. Admin. Code § 140.403(a).

Additionally, a physician or other licensed health care professional must be present with the patient at all times when the telehealth services are being delivered at the Originating Site, and the Distant Site provider must be a physician, physician assistant, podiatrist or advanced practice nurse who is licensed by Illinois or the state where the patient is located.[25] Furthermore, the regulations set forth specific requirements for records that must be maintained by both the Originating Site and the Distant Site in order for telehealth services to be eligible for reimbursement.[26]

b. Originating Site Reimbursement for Telemedicine

Reimbursement under Illinois Medicaid is addressed in two main categories: payment to the Originating Site and payment to the Distant Site. The following Originating Site providers will receive a facility fee for each telemedicine service in which they participate: physician's offices, podiatrist's offices, local health departments, community mental health centers, licensed hospital outpatient departments, and substance abuse treatment centers licensed by the state.[27] However, providers who receive reimbursement for a patient's room and board are not eligible for reimbursement as an Originating Site provider.[28]

An encounter clinic serving as the Originating Site will be reimbursed for each medical encounter, and will be responsible for reimbursement to the Distant Site provider.[29] The HFS Informational Notice cautions the Originating Site encounter clinic to ensure and document that the Distant Site provider meets HFS requirements for telemedicine services, because the clinic will be responsible for paying the Distant Site provider.[30]

c. Distant Site Reimbursement for Telemedicine

HFS states that Medicaid participating providers will be reimbursed for the appropriate CPT code for the telemedicine service rendered.[31] Nonparticipating providers may be reimbursed by the Originating Site provider, but will not be eligible for reimbursement from HFS.[32] An encounter clinic serving as the Distant Site will be reimbursed as follows:

a. If the Originating Site is another encounter clinic, the Distant Site encounter clinic will not receive reimbursement from HFS. The Originating Site encounter clinic is responsible for reimbursement to the Distant Site encounter clinic; and

b. If the Originating Site is not an encounter clinic, the Distant Site encounter clinic will be reimbursed for its medical encounter.[33]

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[25] 89 Ill. Admin. Code § 140.403(b)(1).

[26] 89 Ill. Admin. Code § 140.403(d). Please see Appendix A for a list of these medical record-keeping requirements.

[27] 89 Ill. Admin. Code § 140.403(a)(4).

[28] 89 Ill. Admin. Code § 140.403(c)(1)(C).

[29] 89 Ill. Admin. Code § 140.403(c)(3)(A). Illinois Medicaid draws a distinction between telehealth provided by encounter clinics and telehealth provided by individual practitioners. Because the eConsult system is not used by individual practitioners at this time, those provisions have not been addressed. "Encounter clinic" is defined as a Federally Qualified Health Center, Rural Health Clinic or Encounter Rate Clinic all as further defined in 89 Ill. Adm. Code 140.461. *Id*.

[30] HFS Informational Notice, *Re: Expansion of Telehealth Services* (Jan. 12, 2010) (http://www.hfs.illinois.gov/html/011210n2.html) (accessed Mar. 22, 2016).

[31] 89 Ill. Admin. Code § 140.403(c)(2).

[32] *Id*.

[33] 89 Ill. Admin Code § 140.403(c)(3)(A).

FAQ #5. Will eConsults be Reimbursed Under Medicare?

Although states may use telehealth to integrate coverage for those patients dually eligible under both Medicare and Medicaid through the Affordable Care Act, they have less flexibility to determine Medicare telehealth coverage than they do under Medicaid.[34] Medicare limits telehealth reimbursement to more narrow categories of services and locations.[35] For example, Medicare reimburses only for real-time telehealth interactive audio and video conferencing by a specified health care professional at a Distant Site, and generally only reimburses for telehealth services to patients in communities that are federally designated rural Health Professional Shortage Areas or in a county outside of a Metropolitan Statistical Area.[36]

FAQ #6. What are Current Trends in Telehealth Reimbursement in Other States?

Almost all states' Medicaid programs have some form of coverage for telemedicine services, and many states permit a variety of technology applications.[37] A common trend among states is to remove restrictions on providers and type of technology used, and to adopt laws ensuring coverage parity under private insurance, state employee health plans, and/or Medicaid plans.[38]

In fact, 29 states have telemedicine parity laws that require private insurers to cover telemedicine services comparable to that of in-person services, including many that authorize state-wide coverage rather than limiting coverage to rural areas.[39] However, there are still a significant number of states that either do not have any parity law or that maintain several restrictions to parity.[40] Moreover, some states only cover synchronous communications and many do not provide any coverage at all for telemedicine.[41] Generally speaking, while Illinois has made some progress with its telehealth laws, the state has not expanded its telehealth coverage as significantly as other large states.[42]

Increasingly, states are using telemedicine to fill provider shortages and ensure access to specialty care. Seventeen states and the District of Columbia do not restrict the type of healthcare provider allowed to provide telemedicine as a condition of reimbursement.[43] The following highlights some trends in coverage of specialty services for telemedicine under Medicaid in other states:

- Most states cover an office visit or consultations with specialists.[44]
- For mental and behavioral health services, generally mental health assessments, individual therapy, psychiatric diagnostic interview exam and medication management are the most covered via telemedicine.[45]
- 17 states reimburse for tele-rehabilitative services in their Medicaid plans.[46]

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[34] Kate Blackman, *Covering and Reimbursing Telehealth Services*, National Conference of State Legislatures Legisbrief, Vol. 24, No. 4 (January 2016) (http://www.ncsl.org/documents/health/lb_2404.pdf).
[35] *Id*.
[36] Kaszak.
[37] Thomas & Capistrant at 3.
[38] *Id*.
[39] *Id.*
[40] *Id.*
[41] *Id.* at 4.
[42] *Id.* at 42.
[43] *Id.* at 4.
[44] *Id.*
[45] *Id*.
[46] *Id*.

APPENDIX A

ILLINOIS MEDICAID RECORD-KEEPING REQUIREMENTS FOR TELEHEALTH SERVICES

(89 Ill. Admin. Code § 140.403(d)
As of January 29, 2010)

d) Record Requirements for Telehealth Services

1) Medical records documenting the telehealth services provided must be maintained by the originating and distant sites and shall include, but not be limited to, the following:

A) The records required in Section 140.28;

B) The name and license number of the licensed health care professional or other licensed clinician present with the patient at the originating site;

C) The name and license number of the provider at the distant site and, if the service involves telepsychiatry, documentation that the physician has completed an approved general psychiatry residency program or an approved child and adolescent psychiatry residency program;

D) The locations of the originating and distant sites;

E) The date and the beginning and ending times of the telehealth service; and

F) The medical necessity for the telehealth service.

2) When the originating site is an encounter clinic, records from the distant site must also be maintained.

3) Appropriate steps must be taken by the originating and distant site staff to assure patient confidentiality, based on technical advances in compliance with all federal and state privacy and confidentiality laws.

4) The type of interactive telecommunication system utilized at the originating and distant sites shall be documented.

5) The billing records related to the use of the telecommunication system shall be maintained as provided in Section 140.28.

Exhibit B

MEDICAL HOME NETWORK

What is eConsult?

eConsult
Access to information. Access to care.

eConsult enables primary care providers (PCPs) to electronically consult (eConsult) with specialists regarding a patient's specialty care needs. eConsult addresses the common barrier of difficult access to specialist care for PCPs and care teams trying to deliver high-quality, coordinated care for patients.

PCPs and care teams can take advantage of this secure, web-based platform in order to communicate quickly and effectively with specialists. Through eConsult, PCPs can submit an electronic consult to a Specialist Reviewer to ask questions relevant to patient care, procure recommendations for treatment or testing, and establish the appropriateness of a referral.

What are the benefits of EConsult?

- Informed and effective initial specialty visits
- Reduced unnecessary referrals and no-show rates
- Faster access to specialists
- Decreased wait times for specialty appointments resulting in improved patient satisfaction
- Streamlined electronic communication between PCPs and Specialists
- Enhanced quality of care with better clinical documentation
- Expanded impact and efficiency of primary care
- Improved patient engagement through multi-modal communication channels (web, mobile, text, IVR, video)

HIGHLIGHTS

- **INNOVATIVE**
  Secure, web-based tool enables quick and effective communication with specialists.
- **TRANSFORMATIVE**
  Offers enhanced collaboration between physicians and specialists, through e-consultations and pre-qualified referrals.
- **AGILE**
  EHR-agnostic and easy to implement – exchanges patient health information, including lab results, clinical images.

Impact

eConsult is changing the access point to specialty care: using a peer-to-peer approach that allows physicians to communicate at their convenience, most cases are resolved without the need for face-to-face visits and specialists can focus on complex patient cases.

REAL RESULTS

COOK COUNTY, ILLINOIS	**~200,000**	total eligible patients	**LOS ANGELES COUNTY, CA**	**+900,000**	total eligible patients
	<1 day	average reviewer response time		**3.2 days**	average reviewer response time
	89%	show rate for scheduled appointments		**60%**	reduction in average wait time for a specialty appointment
	55%	reduction in face-to-face appointments with specialists		**46%-64%**	reduction in face-to-face appointments with specialists

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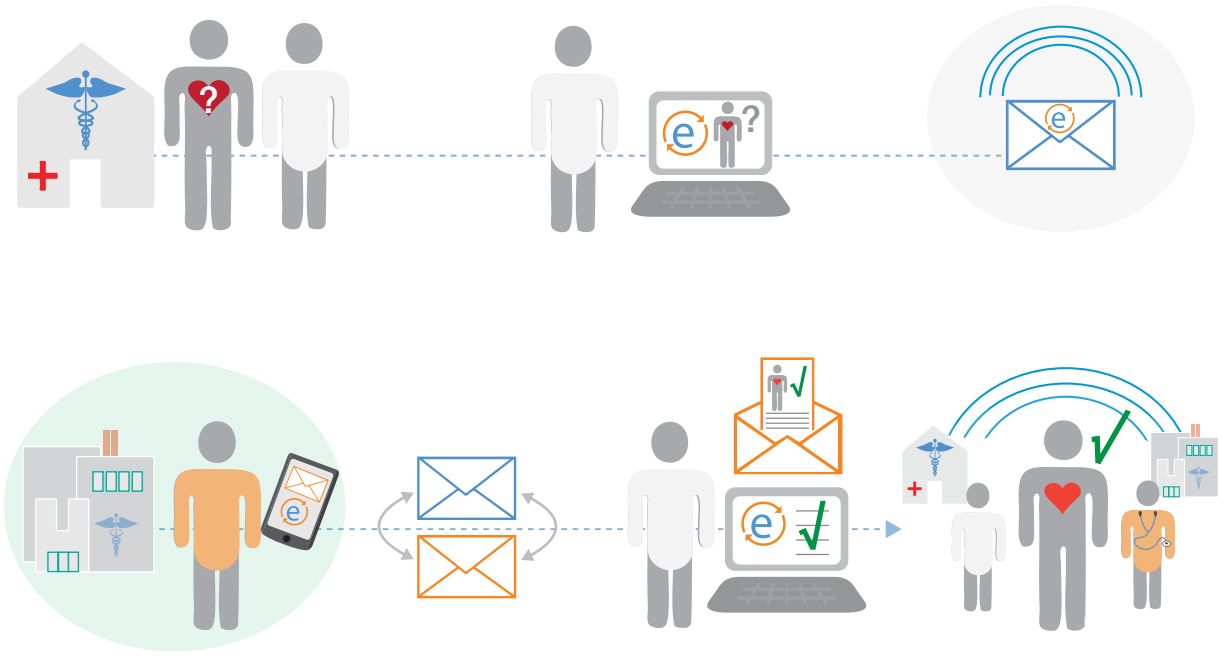
How does eConsult work?

THE PRIMARY CARE PROVIDER (PCP) ROLE:

- The PCP or care team staff initiates the process by requesting a specialty consult.
- The PCP or care team staff includes a brief history of the patient's present medical condition, pertinent clinical information, any recent test orders or results.
- The PCP submits a clinical question to the specialist to begin the dialogue.

THE SPECIALIST REVIEWER'S ROLE:

- The specialist will receive a secure email alert that a PCP has submitted a consult.
- The specialist will log in to the portal to review and respond to the PCP. The specialist can request more information, suggest a diagnostic plan, provide treatment recommendations, request further work up, or recommend a face-to-face visit at the specialty clinic.
- An email alert is then sent to the PCP informing them that the electronic consultation has been answered.



BUILT-IN DECISION SUPPORT AND REFERRAL GUIDELINES DELIVER EFFICIENCY BY HELPING ENSURE ALL NECESSARY INFORMATION IS PROVIDED BY THE PCP BEFORE THE SPECIALTY CONSULT.

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